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ORIGINAL ARTICLES.

THE EXAMINATION OF CULTURES FROM CASES OF SUSPECTED DIPHTHERIA.*

B. MEADE BOLTON, M.D.,† PHILADELPHIA.

Owing to coöperation on the part of many of our physicians, it has been possible to accumulate certain data in regard to the bacteriologic examination in cases of suspected diphtheria. A full report will be published by the Board of Health, but it may not, perhaps, be amiss to bring before you in advance some of the more interesting and instructive points that have been developed.

From May 30, 1895 to January 1, 1896, there were examined 1421 primary cultures and 1942 secondary, making a total of 3363 cultures. Of the 1421 primary cultures 1207 were made from the throats of persons showing clinical evidence of diphtheria and 214 were made from the throats of healthy persons who had been exposed to infection. Of these cases only those in which the physician made a diagnosis, are of value in comparing the clinical with the bac-

teriologic diagnosis and this comparison shows a remarkable agreement, all things considered. The diagnosis of diphtheria was made by the attending physician in 557 cases; in the remainder of the cases the physician either stated that the case was not diphtheria or left the matter in doubt. But in the 557 cases diagnosed as diphtheria bacteriologic examination showed the presence of diphtheria-bacilli in 507, or 90.2 per cent. In other words at least ninety per cent. of cases pronounced diphtheria by the attending physician had the Klebs-Loeffler bacillus present.

In 148 cases the physician stated that the disease was not diphtheria. The Klebs-Loeffler bacillus was found in forty of these cases: the clinical and bacteriologic diagnosis agreeing consequently in 72.9 per cent. According to this it would seem that in cases of angina which do not show sufficient evidence clinically to be called diphtheria 27.1 per cent. have the same organism present that is usually found in clinically typical diphtheria. Those who call all anginae caused by Loeffler's bacillus

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†Chief of the Bacteriological Division of the Bureau of Health, Philadelphia.

diphtheria would regard these as mild or atypical cases of the disease.

If the 557 cases in which the physicians pronounced the disease diphtheria be taken with the 148 that could not be called diphtheria clinically it will be found that the clinical and the bacteriologic diagnosis agree in 86.4 per cent.

Cultures were taken in 214 cases

more or less exposed get the bacilli in their throats. It would be interesting to know how many of these persons subsequently develop the clinical symptoms of the disease. In fifty of these cases it was possible to determine that the bacillus persisted for 13.3 days on the average.

In 460 cases presenting clinical symp-

Diagnosis of diphtheria given.	Diagnosis of diphtheria confirmed by culture test.	Diagnosis not diphtheria.	Diagnosis not diphtheria confirmed by culture test.	Total number of cases in which diagnosis was given.	Total number of cases in which the diagnosis was confirmed by culture test.
557	507 or 90.2 per cent.	148	108 or 72.9 per cent.	705	615 or 86.4 per cent.
Cases of persons exposed but presenting no clinical symptoms.	Bacilli found.	Bacilli not found.	Unsatisfactory cultures.		
214	89 or 41.5 percent.	95 or 44.3 per cent.	30 or 14 per cent.		

from the throats of persons who had been exposed to diphtheria, but who presented no clinical symptoms. Of these 214 cases, 89, or 41.5 per cent., showed the presence of the Klebs-Loeffler bacillus; 95, or 44.3 per cent., did not show the bacillus and the others were unsatisfactory. It seems, accordingly, that more than one-third of persons

toms of diphtheria the length of time that the bacilli were present, dating from the appearance of the first symptom to disappearance of the bacilli, could be determined. It was found that this varied from seven to ninety-six days, the average being 28.3 days, irrespective of treatment. See tabulated summary of results above.

THE PROFESSION, THE OPTICIANS AND THE PUBLIC.*

EDWARD JACKSON, A.M., M.D.,† PHILADELPHIA.

The use of correcting glasses is still extending, even where it is now most common. Their more accurate adjustment to the needs of the wearer is likely to still farther popularize them.

The employment of the eyes for the seeing of minute objects at short distances becomes more general and constant. A multitude of new stimuli tend toward the greater refinement and delicacy of the average nervous system.

It can be safely asserted that the need for glasses will continue and ex-

tend until there occurs some important change in the direction of our social development.

Who shall measure the eye for glasses? is then a question of some importance, and one about which the medical profession should be able to arrive at some common opinion. It is a question that may be considered from different points of view, and it seems appropriate for discussion in a meeting representing all parts of our profession.

I have no doubt that in the end this work will be done by those who can do it best and cheapest. Only long experience will demonstrate to some just who

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†Professor of Diseases of the Eye in the Philadelphia Polyclinic; Surgeon to Wills' Eye Hospital.

these will be; but from my knowledge of the requirements of the work, I believe that it will ultimately be done by a class of practitioners familiar with the general principles of medicine and surgery, experts as to the diseases of the eye, and specially trained in the methods of measuring refraction and conditions of ocular muscular balance.

A little over one generation ago, prior to the publication of Donders' great work on the *Refraction and Accommodation of the Eye*, the science and art of adjusting glasses for the correction of ocular defects did not exist, and the rudiments of that science and art were held chiefly outside of the medical profession. Practically, each person who got glasses fitted himself with them, with the aid of such hints as the vendor, from his experience, could give. Under these conditions, the use of glasses was comparatively limited.

The new knowledge and skill found the medical profession best prepared to receive them, and in best relation to the community to utilize and apply them; but the subject, naturally, also attracted the attention of those who had heretofore given the public the little help it had in the selection of glasses; and the opticians did not fail to see the advantage of their position and the plausibility of their claim to this sort of work. Had they possessed as broad a training, and had they been as much actuated by the spirit of scientific investigation as the medical profession, they would, at least for a time, have kept the confidence of the public and gotten a larger share of the new work. As it is, we are still in a transition-state. Many fail to recognize which way things are moving, and some are earnestly and conscientiously trying to turn back the current of events; while others seem not to recognize that they are moving at all.

The ophthalmologists have not failed to develop and put forward their views upon the subject; yet I believe the reasons supporting those views are even stronger than they have yet been made to appear.

In reply to the statement that every pair of glasses has a medical bearing, it may be urged that every meal one eats has a medical bearing, every piece of underclothing one wears has a medical bearing; yet one does not run to his doctor

each day with his bill of fare, or go to him for a prescription when he wants a new undershirt. Very true; but the varieties of undershirt one has to choose between are very few; and each individual, when he comes to choose for himself, brings to the choice some considerable experience of the effects of undershirts. Again three or more times a day, from birth, each person has been experimenting in dietetics. Generally some of his most vivid and earliest remembered impressions have been of the results of his investigations in this field of knowledge.

Probably it is to this practical experience of the effects of food upon our own particular bodies, more than to anything else, that reference is made in the saying that "at fifty every man is a doctor, or he is a fool."

The indications for food and clothing are commonly strictly physiologic. Let indications regarding them arise, however remotely, in the domain of pathology, and how quickly not only the food we eat and the clothing we wear, but even the water and other fluids that people drink, and the air they breathe become the subjects of the physician's prescriptions, without question or wonder.

Now, the possible variations of glasses to be chosen from are practically infinite, and the indications for their use almost always lie in the domain of pathology.

Presbyopia may be physiologic; its earliest indications may be physiologic, although always new in the experience of the individual; but these first indications are commonly disregarded; and not until pain or inflammation has occurred, and become sufficiently serious, does the presbyope come to think of glasses. In hyperopia, in astigmatism, in myopia, pain or some other disorder of the nervous system, or some pronounced disease of the eye, or both, are the indications to meet which glasses are required.

The general association of ocular disease with the need for glasses is felt by every thoughtful and conscientious refracting optician.

Scarcely a month passes that I do not receive an inquiry from some optician as to how he can learn something of the

diseases of the eye to enable him to better do his work as a refracting optician. Generally, the only course I can indicate to him discourages him; he has gone too far on the wrong track. But within a month I have talked with a man of fifty, a practical optician all his life, who has felt so much the need of this knowledge that he has entered upon the now-a-days thorny path that leads through a four years' course to the medical degree, simply to acquire this desired acquaintance with ocular disease, which he purposed to use in the fitting of glasses.

Again, the more enterprising optical firms that make a point of "examining eyes free," equally emphasize the point that these examinations will be made by "regularly graduated physicians." So far as I know, every opticians' school in the country—and there are a host of them—is taught by a "regularly graduated physician."

Since the opticians themselves have so completely given away the case as to the importance of medical knowledge to the adjuster of glasses, it might seem superfluous to argue it at length before a medical society. But, really, the opticians are more keenly alive to the medical aspects of a pair of glasses than some of the medical profession. *Rip Van Winkle, M.D.*, cannot see why a man should not go into a store and buy a pair of glasses now, just as his grandfather did two generations before him. Indeed, a medical journal that claims the largest circulation of any weekly medical journal in the country, and which considers itself very bright and up-to-date, speaking editorially of people who suffer from hyperopia, myopia, and astigmatism, but who "cannot afford to go to a specialist," says: "Now, we advise such to go to their family doctor and let him decide whether the optician is sufficient." (*Medical Record*, November 24, 1894.) There is in this city a refracting optician who claims to refract people referred to him by two hundred of its doctors. The claim is without doubt a gross exaggeration, but I have heard from patients—who had learned by sad experience that the advice was not sound—that they had been advised by their family physician to go to this optician. So, perhaps,

this subject is not out of place in the Philadelphia County Medical Society.

Another reason why the work of measuring for glasses should be done by a special class of professional men is that it requires time, thoroughness, exactness. The benefit derived from a pair of glasses is not in proportion to their approach to accuracy of correction. There is often no benefit whatever until the approach to perfect accuracy is very close. Nowhere is painstaking attention to minute detail more productive of benefit. The public may be slow to learn, but ultimately it will learn that the best service in this matter is the only kind of tolerable service; and this kind of attention it will have to pay for. If it is rendered by the refracting optician, as in rare instances I believe it now is, he will charge for his time or he will retire from the business. A refracting optician who came to consult me about wearing glasses himself told me that his plan was to charge twenty-five dollars for a pair of glasses and the fitting of them. The glasses, in gold frames, cost him from two to four dollars. The difference represents a very good fee for skilled services. Some doctors follow this same plan of charging a lump sum for glasses and services, believing that patients will more readily pay this than a professional fee; but the net result to the patient's pocket-book is the same; and in the long run I believe the more frank and truthful plan will grow in favor.

The proper relation of the optician to the prescriber of glasses and to the public is then closely similar to that of the apothecary. He has at present, however, some advantages over the apothecary. While the latter finds his field for the exercise of especial skill more and more encroached upon by the wholesale manufacturer of standard drugs and proprietary preparations, the optician has not only had the opportunity extended for the exercise of his technical skill in the grinding and mounting of lenses, but there has also been opened to him a new field in the fitting of frames to the peculiarities of the individual face—a work properly remunerative and as yet very rarely understood and imperfectly appreciated by the opticians themselves.

This relation of the doctor and the

optician to the public is liable to the same abuses as that of the doctor and apothecary. Collusion, by which the optician gets patronage and the doctor gets a percentage on the optician's receipts, is the same mean, contemptible sort of theft as similar collusion between doctor and druggist; and it is, perhaps, equally common and more unblushing.

An optician in another city recently informed me that doctors had three plans with reference to the glasses they prescribed. A few merely concerned themselves with seeing that the glasses furnished by the optician were the glasses ordered, and that the frames were well fitted. A larger number bought the glasses of the optician at wholesale rates, and sold them to the patient presumably at retail rates, or for a lump sum including professional services.

I have heard of the indignation of the students of a certain medical college when they learned that their professor, who followed this plan and was supposed to supply the glasses at cost, had been pocketing an extravagant profit.

The third plan was for the doctor to send the patient to the optician who fitted the frames and charged a full retail price for the glasses, and then credited the prescriber with a large fixed percentage thereof, or with the difference between the wholesale and retail prices, and at stated intervals sent the doctor a check for the amount.

I have reason to think that the same thing occurs in Philadelphia. I have had hints that such an arrangement was possible in various quarters, and have had the whole plan of fraud explained to me by one especially eager to perpetrate it on my patients if I would make them his customers. I have seen what appeared to be photographs of checks and stubs from the check-book of a firm of opticians, representing the payment of such commissions to a member of this Society. In this case I offered, if those who claimed to know the facts would testify before the Censors of the Society, to take upon myself the unpleasant office of preferring charges; but no one was willing to appear as a witness. One of the opticians, hearing of my offer, came to me to threaten prosecution for libel. It occurred to me that this would be just the thing, that in a court of justice

one could compel unwilling witnesses, and I tried to encourage him to make good his threat; but he never showed any inclination to pursue the matter further.

This incident helped to convince me of the utter inadequacy of our Code of Ethics, and the machinery for its enforcement, to secure even common decency on the part of those members of the profession whose natural tendencies are in the opposite direction. I think, though, that it does good to discuss such matters in a meeting like this. It certainly must make one uncomfortable to hear his detestable course of action properly characterized, and not dare to say a word in defence of it, lest he should brand himself as one of those lacking in common honesty.

The open discussion of such matters leaves no excuse for any to sin through ignorance; and as the relations of the oculists and the opticians to the public become more settled and better understood, we may hope that such abuses will diminish. Perhaps it will help matters to regard with suspicion the prescriber who has all his prescriptions filled at a certain store or stores; and not to recommend the optician who is known to seek to extend his business by such illegitimate methods.

If it be desirable that the measurement of the eye for glasses should be done by a special class of practitioners, how shall it be brought about? In this day the first thought of many will be, by special legislation directed to that end. This, I think, is quite impracticable. Other reasons against it might be urged, but this alone is sufficient. There is not any sufficiently defined class of persons in the community to whom the right to prescribe glasses could be confined by legal enactment. It has been suggested to confine it to legal practitioners of medicine; but the mass of medical practitioners are not competent to do this work, and to confer upon them the especial right to do it on any other ground than that of peculiar fitness would be a gross violation of legislative principles. Nor is special legislation needed. I believe that by giving better and cheaper service in this direction of fitting glasses, and putting itself in communication with those who need such

service, that portion of the medical profession doing this work will get practically all of it to do.

The great reason why people go to opticians to have their eyes fitted is that some doctors do not do any better work in this direction than the opticians. Apparently some of those engaged in ophthalmic practice, and some who are on other accounts justly regarded as leaders in the profession, think it beneath their dignity to apply their attention earnestly and seriously to the measurement of refraction. They cannot stoop to give a "refraction-case" time and careful attention, to apply to it diversified and repeated tests. They prefer rather a few hasty and superficial trials, a jump at a conclusion, an assumed air of wisdom, and a dogmatic opinion, often ridiculing the idea of benefit from accuracy in the adjustment of glasses.

From the offices of such prominent practitioners, and their more numerous imitators, goes out a steady stream of patients who know by their own experience that doctors cannot fit glasses any better than the opticians; and the impression they make on public opinion can only be eradicated after the removal of its cause.

I am glad to say that there is less of this influence to be combated in Philadelphia than in any other large city that I know of; still we feel it here. It will have to be recognized that good work is never done by one who does not think the work is worthy of his best effort, and that the measurement of the refraction of the eye is something apart from other branches of medical diagnosis, requiring its own special apparatus, special methods, special training and experience.

A few words as to the cost of this service. Evidently the editor of the *Medical Record* makes the supposition that there exists a large class of the community who have a "family physician" but "who cannot afford to go to a specialist" the occasion for his remarkable utterances on the usefulness of refracting opticians. The patient who could not afford to go to a specialist until he had spent considerable money for glasses at the optician's, or lost days from remunerative employment in waiting on the service of a public clinic, and

who then comes, anxious to have the thing "done right," is a very familiar figure in the office of the ophthalmologist.

The fees of the expert of large reputation and full practice are larger than those of the average practitioner in any branch of work, and if by specialist this kind of practitioner is always meant, it is one matter; but it is not more necessary that all cases of refraction should be measured by the famous teacher or great hospital surgeon than it is that such should set all fractures or treat all cases of heart-disease. There exists in ophthalmic practice a mass of younger, less known, but well-trained and conscientious workers, who are thoroughly competent to do such work, and of whose existence and merits the general practitioner should inform himself, as he would be the first to deny to these professional brethren the advantage of those methods of advertising by which he becomes acquainted with the claims of opticians.

Let this also be borne in mind: The specialist in ophthalmology knows none of the circumstances of the home or the business-relations of his office patients, such as the family physician can observe in his visits to them. Hence his only proper course of procedure in justice to himself is to charge a full fee, even when, were he better informed, he would make a reduced charge. If the family physician will bear this in mind and inform the oculist of the circumstances of his patient, much of the apparent reason for thinking the latter illiberal, or extravagant in his charges, will vanish.

Dr. Charles B. Kelsey, in a letter to the *New York Medical Journal*, reports a successful laparotomy for intussusception in an infant three months old. The symptoms had existed only twenty-four hours, but the caput ceci was presenting at the anus. Mr. Frederick Treves writes to Dr. Kelsey that he cannot recall a case of successful operation for this condition in a child of three months or under, and he thinks it probable that Dr. Kelsey's case is unique. Whether it be unique or not, it is certainly an argument for the early operative treatment of intussusception.

THE SURGICAL TREATMENT OF INSANITY.*

ERNEST LAPLACE, M.D., LL.D.,† PHILADELPHIA.

While it is evident that a surgical procedure must not be resorted to in every case of insanity, still it is also evident that certain cases of insanity are due to impaired mental function resulting from a removable cause. In its widest sense, insanity is as vague a term as the word fever. Just as fever means a symptom of many disturbances from various causes, affecting certain trophic centers of the brain, removable or modified according to the nature of the fever, so also does insanity imply to me the evidence of improper function of the intellectual centers of the brain. I am prepared to consider it as a symptom of a *cause* which on careful study of the case may be determined as removable, or not.

The art of cerebral localization has advanced to the point of enabling us today to locate with a fair degree of precision the cause of impaired function when existing in the motor or sensory area—not so, however, should the intellectual area be affected. In this regard we are still backward; hence the total inability to locate precisely the part affected in the vast majority of cases of insanity and the confinement of the mentally-diseased in asylums, where, unfortunately, too little is done to rescue them from their living death.

There are cases, however, in which the history of traumatism distinctly exists as the predisposing cause of the insanity. Let there lurk in the system a tuberculous, syphilitic, gouty or other diathesis, and the traumatism producing upon the area of the brain affected a spot of least resistance, an inflammation results, acute or chronic, which will temporarily or permanently alter the function of the area affected.

The brain, encased in its bony box cannot be seen and treated when affected by disease or traumatism as any superficial portion of the body can.

Nevertheless, it is just as likely as the rest of the body to be the seat of pathologic phenomena, which elsewhere, would be met and checked by local treatment. It is to enforce this idea by the practical results already obtained, that I desire to relate the following cases.

CASE I. J. F., aged thirty-four, residing in Philadelphia, was struck on the head two and one-half years ago by a falling brick. Subsequently he suffered from severe headaches; although at no time was there any outward sign of injury. Within two months he became insane and was then confined in the Philadelphia Hospital for the Insane during six months. He was taken back to his home, when I was called to see him for a totally different trouble. The history of injury to the skull, together with a few spots on the body, suggested to me the possibility of syphilis complicating whatever harm to the brain a traumatism of the skull might have produced. I, therefore, trephined over the seat of injury, on July 20th, 1895, at St. Joseph's Hospital, nine months after the insanity had declared itself. A button of bone one-half inch in diameter was removed over the parietal eminence, and the dura was found white and thick, and quite adherent to the button. The rongeur forceps was used to remove bone above and below to the extent of an inch and one-third inch wide. The dural separator was inserted so as to separate the dura from the skull antero-posteriorly, above and below, over the whole area of the left hemisphere. The patient withstood the operation well, and had neither pain nor fever following the operation. He was immediately placed on specific treatment. During the three weeks after the operation he improved gradually, recognized his relatives, and six weeks after the operation he left the hospital having entirely recovered his reasoning faculties.

Here the traumatism, without producing a fracture of the skull, had caused

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† Professor of Surgery and of Clinical Surgery in the Medico-Chirurgical College, Philadelphia.

a local development of syphilitic phenomena, which, after surgical interference, became absorbed under specific treatment, thus restoring the impaired intellectual centers to their proper function.

CASE II. Mrs. D., aged fifty-four years, married, was struck by her husband with his fist on the left side of her head. A short while afterwards she showed signs of dementia, and gradually became violently insane. She was under restraint during one year in Shenandoah, Penna., where she lived. She was being taken to the Pennsylvania Hospital for the Insane when I was asked to see her. She was in a great state of excitement or violent delirium, causing so much disturbance as to be handcuffed and isolated. She was trephined in the left temporal region, at a spot where her son told me she often placed her hand, although she never complained of pain. The bone was found much thickened; the diploe was fully one-fourth of an inch in thickness and from it came about four ounces of sero-sanguinolent fluid. There seemed to have been a hyperplasia of bone in this locality. We finally reached the inner table and concluded that the skull in that region was at least twice the normal thickness. The dura was very much congested; it was carefully separated, and the parts were packed with iodoform-gauze. On the following day the patient had completely quieted down, and would remain in bed without the straps used to restrain her before the operation. Within a week her reason was entirely restored and three weeks after the operation she returned to her home absolutely well, and is so still, at this moment, six months after the operation.

CASE III. J. W., a young man, aged twenty-six years, suffered for four months from melancholia amounting to insanity. His sister had committed suicide four months before, after he had quarrelled with her, and thenceforth he was pursued by the thought of having caused his sister's death. He sank into the deepest melancholia, meditating suicide and unwilling to work or even talk to anyone. His melancholia had, however, started over two years ago and became aggravated by his sister's misfortune.

There was furthermore a dullness of intellect amounting to what might result from a chronic meningitis. The patient was trephined in the left temporal region and a strip of bone, one-quarter inch wide, was removed from the anterior portion of the skull, corresponding to the coronal suture. Considerable trouble was experienced in checking the severe hemorrhage that occurred during the operation, the patient being no doubt somewhat hemophilic. On regaining consciousness after the operation he was told how absurd it was to think that he was the cause of his sister's death, and in the course of a few days he began to take an interest in matters in the ward of the hospital, gradually becoming brighter and helping the nurses. One month after the operation, on November 5, 1895, he left the hospital, feeling perfectly well, making no further allusion to his sister's death, and desirous of returning to work.

In this case there was no history of traumatism, but simply a functional disturbance very much on the general lines of so-called *idiopathic* diseases, which remain so classified only so long as science does not place them where a true knowledge of their cause would entitle them to be.

CASE IV. J. O'D., aged forty-five, a laborer, had been well all his life. He was seized some ten months ago with symptoms of "delirium of persecution."

He imagined that people on the street were conniving for his destruction. He saw in all advertisements of newspapers the schemes of people who wished to estrange his wife from him. He complained of constant frontal headache. He refused to work. Being taken to me by his brother, I advised a craniotomy over the region of the headache. This was acceded to. On May 22, 1896, I performed the operation and found the dura quite adherent to the skull. The adhesions were carefully separated. The operation was very bloody. The patient has not shown signs of any delusions since. He is about to return home, not knowing precisely why he came to the hospital, and denying that he ever thought that he was haunted or persecuted by anyone.

I venture to offer the following conclusions:

1. Traumatic insanity is dependent upon an appreciable pathologic condition incident to the traumatism and interfering materially with intellectual function.

2. Idiopathic insanity is dependent upon an inappreciable alteration of the brain-substance interfering with intellectual function.

3. The relief of pressure by trephining and extensive craniectomy is a harmless procedure. It is a most valuable adjuvant to promote, with the aid of suitable medication, the absorption of deep exudates and the drainage of fluids from

the cranial cavity, which would otherwise be retained and act as irritants.

4. The foregoing cases speak for the accurate diagnosis and prompt surgical interference in such cases of insanity as follow traumatisms. When we remember that the brain in its thick meninges is furthermore encased in the skull, and how it is exposed to the same pathologic reactions as the rest of the body, we will feel less loath to interfere so as to apply to the brain and the meninges the same common-sense rules of surgical treatment as are applied to the rest of the body; but to do this, we must reach the parts affected.

A CASE OF VARICELLA GANGRENOSA. DIPHTHERIA, RUBEOLA, AND VARICELLA OCCURRING AT THE SAME TIME.*

J. P. CROZER GRIFFITH, MD.,† PHILADELPHIA, PA.

Charles F., aged twenty-two months, was admitted to the Children's Hospital of Philadelphia on February 25, 1896, suffering with pneumonia. The family history was good, except that the father was just convalescing from pneumonia and looked tuberculous. The child had always been healthy previously. On February 20th he began to have cough and fever. On admission to the hospital he had frequent cough (which appeared to be painful), fever, rabbia and labored respiration. Physical examination upon the following day disclosed evidences of croupous pneumonia of the upper part of the left lung. By February 29th the consolidation had increased and all the symptoms of pneumonia were well marked, and there was also decided indications of meningitis. By March 2d the pneumonia was resolving and convalescence was established. The attack had been a severe one and had threatened to be fatal. On March 14th, the child developed slight follicular tonsillitis, and cultures showed the presence of the Klebs-Loeffler bacillus. The general condition was, however, excellent, and the evidences of tonsillitis disappeared rapidly. On March 18th the rash of measles appeared, not preceded by rise of temperature, but

five hours later the thermometric reading was 104° F. On March 21st a vesicular eruption appeared, resembling that of varicella (which, like measles, was prevailing in the house at the time) but the vesicles increased rapidly in size until they were of a bullous character and rendered the diagnosis somewhat doubtful. On March 24th and 25th the child was examined by Dr. J. A. Cantrell, who agreed with me that the case was one of varicella gangrenosa. The cause of the eruptions from the beginning and for the first ten days, as condensed from notes taken by Dr. Cantrell and myself, was much as follows:

The rash appeared first as a vesicle of varicella. This vesicle rapidly increased in size, because somewhat bullous and then burst, leaving an erythematous area having an appearance as of an emptied blister with the cuticle still preserved and drying over it. Most of these areas were not larger than a split pea or a ten-cent piece in size, but some were as large as a quarter of a dollar. In a few days ulceration began in some part of the erythematous areas, and extended, forming cup-shaped excavated ulcers, oval or rounded in character with ragged edges and about two lines in depth. From some of these an ichorous pus was discharged, while over others large dark-brown or black-red

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†Clinical Professor of the Diseases of Children in the University of Pennsylvania.

crusts formed. Two large lesions that were present over the right scapula and two over the posterior surface of the left arm showed a tendency to coalesce. Early in the attack the trunk and arms were principally involved and there were but few lesions on the head and none on the lower extremities. But little inflammatory areola surrounded the ulcers. There was little induration, and the ulceration was, as stated, not deep.

This condition did not continue. New vesicles formed and ulceration extended, and on March 31st it was noted that erythematous spots, rapidly changing to vesicles, but not yet ulcerated, were now forming on the legs, and that ulceration was extending over the scalp, forming superficial lesions, the size of a twenty-five-cent piece, without much crust. Ulcers were present on the neck and face, as well as elsewhere over the body.

On April 2d, twelve days from the first development of the eruption, the child was losing ground rapidly and was very weak. There were a great many large, superficial ulcerations scattered over the body, but most on the scalp and on the back. The inflammatory areola was more marked in places, but not generally so. The child was having sinking attacks, apparently from cardiac failure, with shallow and labored respiration and rumble in the chest. Fever of moderate intensity had been present from the onset of the tonsillitis, on March 14th. The child died on April 4th with symptoms apparently of broncho-pneumonia, although no physical examination was made, owing to the extreme weakness of the little patient.

The only interesting feature of the autopsy was the discovery of diphtheric membrane in the trachea, but not in the larynx.

Varicella gangrenosa is unusual enough to warrant the report of this case. The description of the disease dates from Hutchinson, although it was mentioned long before this. It appears to have been met with chiefly in England. German text-books make but little or no reference to it and it would certainly seem to be rare in our country. I saw a case within a couple of years, in which one spot upon the abdomen developed into a deep slough, but I have never met with so extreme ulceration as in the

case now reported. The photograph presented shows the appearance of the child when the disease was approaching its height. Unfortunately the head-covering was not removed, and the ulceration of the scalp does not show.

The eruption in this case exhibited certain peculiarities in which it differed from the rash of gangrenous varicella, as ordinarily described. It did not, namely, proceed uniformly onward from a vesicle to an ulcer, but first became a vesicle, then usually a bulla, and then generally burst and dried, as though this were to be the last of it. Then ulceration began in the affected region. Again, although the ulceration was extensive, it did not extend at all deeply—not even through the entire thickness of the skin.

The steady development of new vesicles over so long a period was different from what is observed in an ordinary case of varicella, in which the production of vesicles should have ceased much earlier.

It is probable that this ulcerative process is not characteristic of varicella alone, but may attach itself to other conditions in which great debility exists. In the case reported, however, there seems little reason to doubt that the disease was primarily varicella, as this affection was prevalent in the hospital at the time, and the early appearance of the eruption was entirely that of chicken-pox.

It is interesting to note that the child seems to have suffered at one time from three infectious diseases—diphtheria, rubella and varicella.

The statement has been made that all post-mortem examinations in cases of varicella gangrenosa have shown the presence of tubercles. No tubercle, however, was found in this case.

I regret that no bacteriologic study of the pus from the ulcers was made. All the officers of the hospital were so overburdened at the time with the unusually large amount of severe sickness prevailing in the institution, that this examination was neglected.

I have not entered at all upon the literature of the subject, as a very full resumé is contained in a recent article by Spivak, and in a discussion of it by Cantrell, in the *Transactions of the Philadelphia County Medical Society*, for 1895.

CURRENT LITERATURE CONDENSED.

Some Cases of Cerebral Surgery.¹

CASE I. A man aged fifty-nine, who fell through a dust chute striking upon his head. He presented ptosis on the left side, hemorrhage from the left nostril, motor aphasia and the pupils were midway between contraction and dilatation and did not react to light. There was no paralysis of the limbs nor of the face. The autopsy showed that the symptoms were each dependent upon separate lesions. There was found rupture of the middle meningeal artery on the left side, a fracture of the left orbital plate and also a distinct, separate fracture of the cribriform plate on the left side.

CASE II. A patient presenting Jacksonian epilepsy, the convolution always beginning in the left leg, then involving the left arm, the left side of the face and then becoming general. Following the convolution the patient would have left-sided paresis which would only remain for a few hours. After the attack he would become maniacal in which condition he was dangerous to those about him. The convulsions in this case occurred in groups so that he would have ten or fifteen in a day. Because of the symptoms, trephining was done over the leg centre on the right side of the brain. A varicose vein in the diploe was found to have ulcerated through the internal and external plates of the skull and had also caused absorption of the dura mater at one point. At this point there was a small hernia or protrusion of the pia and brain. No other lesion was discovered. The course of the vein was bitten out with rongeur forceps and the channel in the diploe plugged with a sterilized match. Following the operation the patient was free from epilepsy for six months. After this he began to experience pain in his left leg and there was a gradual return of the convulsions. Believing that the return of the convulsions was dependent upon the adhesions which had formed, the patient was again operated upon nine months after the first operation and a plate of gold foil

inserted in the deficiency in the skull. A few months subsequently, the patient died suddenly in the night from causes unknown. Subsequent to the operation he experienced no convulsions. An examination of the head after death showed no gross lesion of the brain. The gold plate had very effectually accomplished the purpose for which it was inserted.

CASE III. The patient in this case had an inflammatory condition in the left upper eyelid which went on to suppuration. This was opened and the patient returned to his occupation, of machinist. After being at work for about three weeks, he began suffering with pain in the head, most marked over the left frontal region. He became stupid. On testing the vision it was found to be 20-70 in each eye. A choked disc was present in the left fundus. A paresis involving the right side was found to exist. The deep reflexes were normal. Temperature was slightly subnormal, the pulse was irregular and hard. The diagnosis of cerebral abscess of the left frontal lobe was made, and a trephining over this area and exploration of the brain in this region led to the evacuation of an abscess containing three ounces of pus. The patient recovered and is now in his usual condition of mind and body.

CASE IV. In July, 1895, the patient was treated for an acute otitis media. This condition persisted in spite of treatment. On the 13th of October he was found comatose, pulse about ninety, pupils contracted, slightly reacting to light, Cheyne-Stokes respiration. This condition continued until the following morning when he was removed to the Cincinnati Hospital. That evening his temperature was 103, he was delirious, pulse was rapid, he had divergent strabismus, no evident facial paralysis, pulse 132, respirations twenty-six. He became very restless and had to be restrained. The reflexes were present and active; slight trismus was noticed. In view of the fact that these symptoms followed the ear trouble and also in view of the very evident meningitis, it was

¹ Dr. J. C. Oliver, Cincinnati, O., Section of Surgery and Anatomy, American Medical Association, Atlanta, Ga., May 6, 1896.

deemed advisable to trephine over the temporo-sphenoidal lobe for possible abscess. This was done with a negative result. The left lobe of the cerebellum was then opened with likewise a negative result. The patient died within an hour after the operation. *Post-mortem* showed diffuse purulent meningitis involving both the base and the convexity. There was no localized accumulation of pus. The infection in this case followed along the carotid canal.

The Exploration and Treatment of Fissures from Skull Fractures.

Dr. Beach says of the patients who survive the immediate effects of injury, a number are subject to a comparatively slight rise of temperature for a short time, associated with varying symptoms of compression, and ultimately recover. The remainder improve for an uncertain period and then develop a temperature that gradually rises as the patient sinks to his death. It is possible that of this last group some are due to chronic inflammation of the brain tissues, following their contusion or laceration and the interference with their nutrition through the pressure effects of masses of clot, added to the degenerative changes characteristic of these processes. The reduction of this mortality is one of the most interesting problems that now confronts the surgeon. As an entering wedge towards its solution, the importance of a series of observations that will establish beyond doubt the relation of sepsis to the fatal cases cannot be overestimated. In searching for the source of infection, one is impressed with the freedom and thoroughness with which the immediate region of direct violence is cleansed and dressed now-a-days, removing from it all suspicion of contamination. Of the more remote sources of infection, the common association of bloody and serous discharges from the ear and nasal passages suggests the possibility of bacterial infection through the extension of a fracture by fissure to the internal ear, which may be abundantly able to supply infecting material to the retained products of

chronic ear-disease. Any laceration of the *membrana tympani* must establish direct communication with the outer air on the one side to the fissured fracture in the temporal bone, and this same fissure is in communication internally through the Eustachian tube with the cavity of the nasal pharynx, which is a hot-house for microbial infection. Fissures communicating directly with the nasal cavity are of necessity open to the same infective influences. Another explanation for fatal cases must be found either in the character of the injury to the brain and its vessels or that of the fissures through which they escape. A fissure extending through loosely fractured bone would be more likely to supply an avenue for infected material to reach the skull cavity than one that could be barely detected and closely resembled a crack in glass or porcelain. Should such a fissure extend in the direction of the internal ear, the difficulty of making that region aseptic and free from the possibility of contamination of the brain is a serious one, especially in old cases of otorrhœa.

The treatment of this condition, to be conservative, should include at the first inspection of the wound a most rigid asepsis. The exploration of fissures with the utmost precision, uncovering the whole circumference of the perforation in the skull for that purpose, and providing unlimited drainage by widening the fissure in a loosely connected form extending in the direction of the base. When nearly fifty per cent. of brain abscesses originate in suppurative ear diseases, the isolation of this region from the brain and its attachments, during the repairs of a fractured skull, demands the serious consideration of the surgeon. It also suggests the question of a more radical cleansing and asepsis of the ear cavities than can be obtained without anaesthesia in cases where the temperature steadily rises, notwithstanding all the precautions which have been taken. The danger in such a plan is, of course, a possibility of forcing aseptic material, under pressure, through a wide fissure into the skull cavity, and emphasizes the importance of a competent primary asepsis of the ears in all fractures connected with them.

²Dr. H. H. Beach, Boston, Mass., Section of Surgery and Anatomy, American Medical Association, Atlanta, Ga., May 6, 1896.

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HAROLD H. KYNELL, A.M., M.D.

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Editorial Staff:

A. L. BENEDICT, A.M., M.D.

SAMUEL M. WILSON, M.D.

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PHILADELPHIA, SATURDAY, JUNE 27, 1896.

EDITORIAL.

THE BICYCLE CRAZE AND ITS RELATION TO HEALTH.

Of all the "new things" that the last years of the departing century has seen, from electricity to skiography, from the kodak to the "new woman," nothing has taken hold upon the people like the "wheeling craze" as it may be called in the absence of a better term. Young and old, of both sexes, all shapes and sizes, of every shade of religious and political belief are enthusiasts, and no one is exempt from the possibility of catching the fever even by being crippled, since a notable figure in this city is a man whose legs are apparently paralyzed and are shrunken and deformed from the

knee down but who yet spends many hours on a wheel specially built for him.

Much has been said against the use of the wheel and even the prevailing hard times have been attributed to it. The theaters complain that the money they used to take from the public on pleasure bent is now saved and expended for bicycles, and that even the time in the evening devoted once to the drama is now given to "going up and down" like a certain personage not recognized by polite society. Churches are neglected for the all-absorbing pleasure

of flying through the air; no more jewelry is bought because the bicycle manufacturer now gets a great part of what used to go for watches and gems; fewer cigars are sold because one cannot smoke while "scorching," paradoxical though it sounds; shoes do not wear out so fast; clothes are not subjected to the same wear and tear, nor does a bicycle suit require the same outlay; cheap caps are worn instead of costly hats; fewer books are sold and read, and the livery-stable keeper lifts up his voice and weeps over the good old times that are no more. Even the saloon keeper claims that his business is not what it was, since wheeling cannot be followed with an unsteady head, and soft drinks are the rule with cyclers.

That the exercise is exhilarating none will deny, that many benefits to general health have been derived from the use of the wheel is patent to the most casual observer, yet it is a question to many whether these facts are not in their turn balanced by disadvantages of grave import. One rider claims a general improvement, another shows a special retrogression. Cases of prostatitis have been attributed to the use of the wheel, and some medical practitioners claim that women who wheel are most liable to uterine and ovarian troubles. Other ills of lesser import are in turn considered due to the bicycle.

That there is some truth on both sides of the question is apparent. Not all can ride the wheel with benefit. Some will suffer in health from its use, and doubtless some of the troubles of the pelvic organs are aggravated by cycling. Yet it is but fair to say that most cases of injury are due not to the use of the wheel, but to its abuse. Immoderate exercise of any kind will defeat the very object that is sought to be attained, and wheeling is no exception to this rule. That some men and a very few women can make a

century run and suffer no ill effects, does not prove that another should ride more than five miles, any more than that all persons should become trained acrobats because some people have developed a high degree of physical health through such occupation. Nor is it necessary that all riders should make of themselves "scorchers" because certain men have devoted themselves to ascertaining the highest rate of speed it is possible for the wheel to attain.

Some of the ill effects attributed to bicycle riding are, of course, due to fast riding and rides too long for the condition of the person wheeling—in brief, to over-exertion in some form, but doubtless more are due to the improper construction of the saddle used. If a man or woman sits on a wheel with all the weight of the body on the soft parts, suspended between heaven and earth like Mahomet's coffin, there cannot help but ensue permanent mischief, and to this defect and its consequences must all rational objection to bicycling be directed. As the matter stands at present the invention of a saddle that will take the pressure off from the soft parts between the thighs and place it on the tuberosities where it belongs will immeasurably advance the sport, and allow many who are now debarred from the advantages to be gained from riding to begin by gradual degrees to participate in all its benefits. What is needed is that the principle of suspension, if it must be employed, be applied in the natural manner, from side to side instead of from front to rear, that greater resiliency be secured and that the anterior projection of the saddle, so far as possible, be modified or abolished. There is no real reason why a seat on a bicycle should not be as comfortable as one on a chair, nor why there should be any ill effect from its use if these points are attained. Of course

there always will be a certain degree of saddle-soreness from the use of the wheel, but this soreness, if in the proper places, will soon wear off and leave no permanent trouble.

Being ridden on a rail, even if the rail has springs and is padded, is not the ideal mode of progression, and yet this is what riding on too many of the saddles in use to-day really amounts to. One may enjoy cycling in spite of this drawback, but how much more, if comfort and hygiene were more considered. The worst of the matter lies in the fact that the first saddle-soreness from the front to rear suspension saddle so often wears off speedily and the rider thinks no more of the warning thus given, while the real ill effects are more gradual in their oncoming, are often not attributed to their right cause, and more often are disregarded as temporary in character until

they become incurable. There must be more bearing surface, and a saddle that one can sit on instead of hanging astride, before the medical profession will unqualifiedly endorse the use of the bicycle.

A little more anatomical knowledge on the part of makers and users of the wheel would be an excellent thing. Once common sense is brought to bear upon the subject there will be no question of tolerating for long rides and somewhat heavy exercise a seat which would not have been given a moment's consideration for any other use than that of cycling, and would not have been for that so long as it has been but for the fact that in the first enthusiasm of the sport, the wheel was accepted as a very good thing as it was, the natural thought of making it a still better one coming later.

SOCIETY REPORTS.

PROCEEDINGS OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

June 10, 1896.

DR. B. MEADE BOLTON read a paper upon
"THE EXAMINATION OF CULTURES FROM
CASES OF SUSPECTED DIPHTHERIA."

[See page 799.]

DISCUSSION.

DR. A. A. ESHNER said that it must be very gratifying to the members of the profession in this city that there should be so striking an accord between the clinical and the bacteriologic diagnosis. All clinicians must recognize that the diagnosis of diphtheria to-day is attended with certain difficulties from the fact that there are many affections of the throat—of the tonsils, of the pharynx and of the adjacent structures—that clinically present manifestations closely simulating, if not actually identical, with those of diphtheria locally, but lacking the virulence of this disease and lacking the profound constitutional

intoxication of diphtheria. It is likely that many of these affections, like diphtheria, are infectious, are transmissible disorders, but differing from diphtheria etiologically. They may be designated diphtheroid if one chooses, i. e., resembling diphtheria, but depending on other causes than the Klebs-Leffler bacillus.

It must be borne in mind in connection with the nature of a doubtful case that diphtheria may have existed and at the time of examination diphtheria-bacilli fail to appear. That this may take place has been shown in some instances in which, while diphtheria-bacilli were not found at the side of the original lesion they were demonstrable in the secondary lesions. At best, failure to find the organisms cannot be accepted as conclusive of their absence. On the other hand the bacilli may be present and yet the symptoms be so mild as to obscure the recognition of the disease. Another point of great importance

as regards these examinations is the long period during which the micro-organisms remain lodged within the air-passages in the situation in which the disease appears, or otherwise, and throughout which period of course these cases are capable of transmitting infection. There is an abundance of clinical observation to show that diphtheria-bacilli may lodge at the site of the disease for many weeks and the organisms that are obtained from these situations are still capable of generating virulent diphtheria. Our notions of the pathology of diphtheria have been very much confused by the introduction of the term pseudo-diphtheria-bacillus, together with what the use of such a term implies. It will be admitted by all impartial observers that diphtheria is due to the diphtheria-bacillus, the Klebs-Loeffler bacillus, and to no other micro-organism, although it is recognized that lesions very closely simulating the diphtheric lesion may result from other influences. It is very likely that many of those which in the past have been designated as pseudo-bacilli were actually diphtheria-bacilli although for some reason or other of lower pathogenic activity.

DR. BOLTON said that it had been very properly stated that in some cases there are anginae which very closely resemble diphtheria but which are caused by a different micro-organism. Recently an article appeared in the *Annales de l'Institut Pasteur** which goes to show that only two organisms are ever concerned in these anginae—either the Klebs-Loeffler bacillus or the streptococcus. A good deal of work has been done in the past that went to show that all the pus-organisms and a great variety of other organisms might cause these anginae, but in this special study, which was carefully made, (the seat of the lesion being first sterilized with hot glass so that no surface-complication entered), in all of these cases the streptococcus was found, most of them in pure culture, in five cases associated with the colon-bacillus and in eleven cases associated with staphylococcus pyogenes but the author accounts for this by unintentional contamination. This work goes to show, and it is so interpreted, that only the streptococcus is concerned when the Klebs-Loeffler bacillus is not. If this dictum be accepted according to the statistics presented ninety per cent. of cases that have clinical symptoms of diphtheria are caused by the diphtheria-bacillus and ten per cent by the streptococcus primarily. After the streptococcus has engendered its evil other contaminating organisms enter into the morbid process.

It is scarcely worth while to dwell upon the question of pseudo-diphtheria-bacilli. It is pretty well proved that they are really the attenuated diphtheria-bacilli.

* Lemoin: Contribution à l'étude bacteriologique des Angines non-diphthériques. *Annales de l'Institut Pasteur*, No. 12, Vol. 9, 1895. Examination of 165 cases showed the streptococcus present in every case, for the most part in pure culture.

DR. EDWARD JACKSON read a paper upon "THE PROFESSION, THE OPTICIANS, AND THE PUBLIC."

[See page 800].

DISCUSSION.

DR. WILLIAM THOMSON said that his experience justified what Dr. Jackson had said in regard to the need for accuracy and care and also that no man can do excellent refraction-work unless he has the temperament for this work and a certain kind of fitness. I was one of the first in this country to turn attention to the careful study of refraction. When I first commenced to practice we had clinical facilities but there was little attention paid to the correction of optical defects.

In regard to getting rid of all errors of refraction fairly and within a reasonable time and then to attempt to solve the problem of binocular vision, not of giving patient merely sight, but of giving him power to work from eight to ten hours a day, is a problem that is worthy of study and one that the ophthalmologist attempts to solve every day in his practice. The ophthalmologist has not commenced to do his best work, the best he is capable of, because the public is unwilling to give him an opportunity to do it and to recompense him accordingly. It is almost impossible after going through a long and tedious examination to get rid of every particle of defect that can be demonstrated or corrected.

In selecting an optician one is to be preferred who sells glasses only upon the prescription of a physician. Such an one is likely to do better work and can be depended upon for accuracy and care.

In New York a project has been agitated for the organization of a national body of some kind that will have the right, perhaps, to make examinations and give degrees so as to place the control of the measuring of refraction in the hands of persons who are not medical people. Of course the first thing to be done would be to give these men the right to use a mydriatic.

Perhaps the more that question is agitated the sooner it will come before the body of the profession in such a way as to enable those who are trying to do scientific and satisfactory work to get their sympathy and their support. The ophthalmologist is not in any sense a specialist alone. He tries to keep himself as well fitted to be a doctor as if he were a general practitioner. There are very few men who have won their spurs as specialists who have not done general work and who could not do this again if necessary. So in this question as to whether refraction-work should be done by men set aside by temperament and opportunity or whether it should be done by so-called opticians, the medical profession will stand with the best men within its ranks who are to-day known as ophthalmologists.

DR. L. J. LAUTENBACH said that Dr. Jackson had approached his subject in a sin-

cere, thorough and proper manner. The matters of which he complained come to a natural solution sooner or later, but this arrives the sooner the more the questions are discussed. The paper distinctly points out how this result is to be reached.

As a matter of history, it is known that some of the profession, in times past, received dividends from druggists. This practice has pretty well disappeared, and it is doubtful whether the number of such cases in Philadelphia to-day amounts in all to more than a handful. Within the last thirty years, this commercial spirit has disappeared more and more, as the sense of honor must ever grow with knowledge.

The matter of opticians being in collusion with eye-physicians is of much rarer occurrence now than it was ten or twenty years ago. That it exists is to be believed, and that opticians offer a certain percentage of their profits to the recommending oculist is too often charged. Dr. Jackson omitted another business matter to which opticians sometimes resort, viz.: Overcharging. There are some opticians in the city of Philadelphia who, when they know that a man appreciates what a thing is worth, will charge him a fair price, and when they have one who does not know what is a fair price (and the poor are the least likely to know), they make much larger profits by charging an extortionate and unjust price. This is not only done by some known to be reliable, but even by some who are supposed to be extremely reputable. The consequence is that the very people who should deserve from the optician the greatest service for the least money, pay the greatest amount of money for the least service. It is well known that the wealthy are the most exacting and demand from the optician the maximum of time and trouble. The class of patients to-day who are most eagerly sought for by opticians are those from the hospitals, because they pay cash and give the least trouble, and, knowing less of the value of frames and glasses, are the more easily imposed upon.

In Dr. Lautenbach's opinion a man is justified, when he writes a prescription for glasses, in sending the patient to someone who can be depended upon—not only that the patient be not overcharged, but that he may have the glasses accurately ground and the frames perfectly fitted, with the assurance that the optician will be willing to make any corrections necessary without extra charge, and will keep the frames perfect in fit in the future. It is proper and right, and an advantage to the patient, that every eye-specialist should designate a series of opticians. He should not allow the patient to go out among them unadvised. He should give the patient the advantage of his knowledge in this respect as well.

The cost of professional services may be materially increased simply through the mistakes of the optician. Thus it may be necessary to return the glasses many times to the

optician before the glasses and their fit are correct.

It is not only the right and privilege of the ophthalmologist, but it is decidedly an advantage to the patient that some one or more opticians should be designated, upon whose ability and accuracy reliance can be placed. The public is becoming educated to the necessity of having its refraction-work done by a physician skilled in the specialty, in preference to one, not a doctor, who is only versed in the mechanics of the eye and the adaptation of glasses. Physicians, too, are becoming more and more aware that eye-specialists are not robbers; that they are willing to make concessions to the poor and those in moderate circumstances. It is not only that eye-physicians have striven with all their might to advance their specialty and broaden their knowledge, but of late there has been a more liberal spirit amongst the general profession. Twenty or twenty-five years ago the specialist was considered almost, if not entirely, outside the pale of pure medicine. It was thought that specialism was going to take work out of the general practitioner's hands. The effect has been quite otherwise, and the general practitioner realized more and more that there is a place for the specialists, their functions being separate and distinct; that they both do work and can work not only for the good of the patient, but for the profession as well as for themselves.

DR. T. B. SCHNEIDEMAN emphasized the fact that the measure of refraction is more than a measure of refraction. It is a measure of the eye, and the physician who makes refraction gives information as to the condition of the nerve, choroid, media, and so on. In that way it might be advisable to go to the man with a better reputation than to go to the man able to do refraction alone. Every refraction done by the oculist should be an index as to the general condition present.

DR. ERNEST LAPLACE read a paper upon
"SURGICAL TREATMENT OF INSANITY,
WITH REPORT OF CASES."

[See page 805.]

DISCUSSION.

DR. A. J. DOWNES related the case of a young woman who had suffered intensely from right-sided headache and was melancholic and depressed, so that some of her friends concluded that she was out of her mind. She was emaciated, and had no digestive power at all; there was slight paralysis on one side. Examination disclosed the presence of a scar on the head and inquiry elicited the fact that the woman had been hit on the head. On trephining over the scar, an organized clot or evidence of it was found under the skull, extending in a circle with a diameter of three and one-half inches. Severe hemorrhage re-

sulted from the adhesions of the dura and the calvarium, and only after the dura had been freed completely did the hemorrhage cease.

Before the operation, this patient did have evidences of mental aberration. She could not think much, only to a certain point. She was always in pain. She was much easier after the operation, and she immediately began to be able to follow out ideas. An attack of typhoid fever, during convalescence, was unattended with mental symptoms. She is now becoming strong and complains not at all of the old head-pain.

DR. J. CHALMERS DA COSTA said that in the unfortunate cases like those related any plan of treatment that offers even the faintest prospect of success is to be looked for with great eagerness and tried with scrupulous care. While a resident physician in a hospital for the insane, Dr. Da Costa had been deeply impressed with the extraordinary suddenness with which acute insanities were capable of disappearing, and chronic insanities of undergoing mitigation. In a case of chronic mania, with the usual unsystematized delusions, excitement and incoherence, in which carcinoma of the breast developed. Extirpation was followed by most remarkable improvement in the mental condition, an improvement lasting for at least four or five months, with abatement of excitement, lessening of insomnia, diminution of incoherence, return of more or less regularity in habits and modes of life. After some months the improvement passed away and the symptoms returned to the old level. In another case, an individual who, while in a condition of acute mania, climbed up a scaffold, fell, became temporarily unconscious, and after the passing away of the unconsciousness rapidly recovered in the course of two or three days, and was able to return to his home in two or three weeks.

Another man, had the extraordinary experience of introducing a ring over his penis, where it remained for a considerable time with the production of destructive ulceration. The ring was removed with some difficulty and the production of much laceration. At the time of the accident he was in the fiercely excited condition of acute mania, but very soon after the accident (a few hours) his excitement wonderfully abated, and in a few days he was apparently well.

In spite of cases like these, we would not be justified in advising removal of a breast, the production of cerebral concussion, or the laceration of the penis for the cure of insanity.

In cases in which distinct injuries and distinct operations have apparently been productive of recovery (as the operation of trephining, etc.), great importance is to be attached to what Dr. J. William White has called the effect of the operation *per se*.

There are no doubt cases, and those of Dr. Laplace may be among this number, in which operation has disclosed the presence of a lesion; but the majority of lesions found in insanity are secondary to and not causative of

the aberration. Again, there are cases of insanity without any detectable lesion, even by the most careful subsequent pathologic examination. The lesions of the true insanities are in the subtle chemistry of the nerve-cell, and are probably beyond the reach of the microscope or chemic reagent.

There is another objection that has been made by most of the surgical students on this subject. There is an inexcusable lack of careful specification as to the exact nature of a case. For instance, in such a case as Dr. Laplace records, with "a delirium of persecution." In an individual who labors under a simple break-down of the nervous system, who is neurasthenic and presents the mental form of neurasthenia, nothing is more common than ideas of suspicion. The question is: Are the delusions systematized or unsystematized? Is the insanity chronic or acute? What is the relation of delusions to the acts? Are these illusions or hallucinations? Is there insomnia? Does the patient eat? Is he destructive? Has he wicked impulses? What is the state of memory, judgment, reason and will? In other words, what is the exact form of aberration? If a chronic insanity with systematized delusions was cured by the operation, the operation is established, but if the case was acute with unsystematized delusions, the condition is one that may pass away of itself, and apparent cure by operation seems to lose a large amount of its significance. To establish this operation, cases must be produced of seminal dementia and paranoia.

There is another point—that is, the question whether an individual has had an injury of some sort, or even a blow. It seems that the mental effect of injury has to be taken under consideration. There is a mass of well-recorded observations in which very slight blows developed phenomena of a most characteristic nature. It is not at all unusual to have the family attempt to account for the insanity by the history of a previous trauma; but the accounts of these injuries are usually very unsatisfactory, and the various members of the family usually disagree as to when the blow occurred, and where.

Another point—All these acute insanities tend to cure in asylums more strongly than people usually acknowledge. For instance, Spitzka gives a percentage of sixty per cent. of cases of acute mania in the first attack that are usually cured. The cure is not unlikely to occur suddenly, especially if there occurs, for instance, a critical disease, or complications like outbursts of boils, or in case of an accident or surgical operation. The interruption of the regular progress of the disease by sudden shock may avert it, but sudden cures are uncertain and untrustworthy. Gradual cure is in favor of permanent cure; sudden cure is in favor of relapse. In thirty per cent. of melancholias cure ensues. Trephining, except in unquestioned trauma, or in cases with persistent localized headache or obvious lesion, does not seem to be indicated. It is not possible to

see that trephining has any broad field of permanent usefulness in these cases. It has been tried over and over again, and over and again it has disappointed expectations.

DR. JAMES M. BARTON said that he had no experience in trephining for insanity, but he recalled several cases in which after other operations he saw decided mental disease disappear. The most recent one in his experience is that of a patient still in the Philadelphia Hospital. The boy was undoubtedly violently insane and was usually strapped to his bed. A mass of carious bone was removed from the head of the tibia, the disease being probably of tuberculous origin. Much to the astonishment of all connected with the case the mental as well as the physical condition began to improve at once and in a fortnight after the operation there was no suspicion of insanity. Several members of this boy's family, including his mother, are inmates of insane asylums.

DR. LAPLACE said in conclusion, that while operation upon such cases as have distinct lesions, or distinct symptoms pointing to a lesion, should be accepted as warrantable today, on the other hand, the other cases that are as yet thought to be attributable to no appreciable lesion are such only because we are unable to recognize the lesion. A lesion must exist and it is the physician's duty to try and find it.

There is no effect without cause; no man or woman becomes insane without cause. There must be to a certain extent an appreciable disturbance if only we had the microscopic eye sufficient to detect it.

With regard to the large proportion of spontaneous cures of cases of acute insanity, it may be said that while a certain number get well it cannot be known if a case becomes acutely insane how long it will remain so; nor can it be known that it is not the first chapter in an attack of chronic insanity. Underlying the whole problem implied in the influence of the operation *per se* is the question of shock.

DR. J. P. C. GRIFFITH read a paper upon "A CASE OF VARICELLA GANGRENOSA."

[See page 807.]

DISCUSSION.

DR. F. WOODBURY raised the question whether there could have been any possible connection between a remedy given to the child and the profuse bullous eruption on the surface of the skin? He related the case of an adult in which five grains (a comparatively small dose) of potassium iodid would produce a vesicular or bullous eruption resembling varicella. This was tried several times and within a few hours, this eruption would make its appearance. It is conceivable that some children may be similarly affected by potassium iodid when given even in very small doses. Dr. Woodbury cited the case of a child five years old with an attack of varicella pre-

ceded by a few weeks of an attack of measles and followed by a fatal attack of confluent small-pox.

DR. J. ABBOTT CANTRELL expressed regret that the name varicella gangrenosa has not been dropped. While the affection resembles varicella and at times develops in the sequence of varicella many instances are reported in which varicella has had nothing to do with the disorder at all.

In some cases an erythematous condition that has been present for some time is followed by a papulo-vesicle or a vesico-pustule, with discharge of the contents, ulceration and the formation of crust.

DR. WM. M. WELCH said that he had seen many cases of varicella, but never one of varicella gangrenosa. The course of the eruption as described in the case reported is not at all common. Usually the first cutaneous manifestation of varicella is an erythematous condition, consisting of very small red spots. This condition does not continue very long and is rarely seen by the physician, as he is usually called too late. These primary lesions are rapidly converted into vesicles. In the course of a few days the vesicles are found to vary greatly in size, some remaining so small as to be scarcely distinctive, while others increase in size by peripheral extension until they become as large as a silver dime, or even larger. These larger lesions may cover considerable areas and be attended with well-marked ulcerative action, even to the extent of destroying the cutis, as in the lesions of variola, but they do not assume a gangrenous condition. These prominent lesions are quite commonly followed by permanent scars which cannot be distinguished from the pitting of small-pox.

A reference to the literature of varicella shows that varicella gangrenosa is rare. A few cases have been recently reported in Philadelphia, and others have been reported in some other cities, especially in New York. It is generally believed that when this complication is seen it indicates a previously debilitated condition of health. Some writers have explained it by supposing that there is present in individuals in whom it occurs a predisposition to gangrene.—Whatever that may mean.

DR. W. B. ATKINSON referred to an epidemic which as the representative of the State Board of Health he had declared one of smallpox although the local medical profession believed it to be one of varicella gangrenosa.

A man who had been conducting a small shoe-mending establishment had been pronounced by the physician in the case to be suffering from nothing more than chicken-pox, and was, therefore, allowed to have everybody come into his place. In a short time there was a number of deaths from varicella gangrenosa, three of them in men not less than twenty-two or twenty-three years of age, two of them in one family, without a history of previous bad health; and the disease

was continually spreading in every direction. After thorough quarantine of every individual case the epidemic, in a very reasonable time, began to decline and no further trouble occurred.

DR. J. F. SCHAMBERG said that the fact that the affection described has been the sequel of so many debilitating and infectious diseases brings up the possibility that it is nothing more than the dermic manifestation of some systemic intoxication, (other than varicella). Diphtheric paralysis, the result of inflammation of motor nerve-trunks, is a common sequel of diphtheria. Dr. Schamberg thought it not at all impossible that an inflammation of some of the cutaneous nerves could be produced and give rise to bullae going on to gangrene—just the condition seen in the case reported. Herpes zoster, a disease that results from a spinal ganglionitis or a neuritis presents all grades of trophic changes from vesiculation to hemorrhage and gangrene.

DR. GRIFFITH added, in conclusion: All of those who had a chance to see the case reported did not have the slightest hesitation in saying it was not small-pox. There was not the inflamed areola, for instance. The experience of those who have seen a good deal of the disease fully justifies the belief that there is a varicella gangrenosa.

All the diseases, however, that run a similar course cannot be called varicella. They need not follow infectious disease; they sometimes occur in pure cases of varicella, developing in children in a bad state of health. They do not need to have been preceded by other infectious diseases. The condition is a distinctly gangrenous one. In bad cases sloughing occurs.

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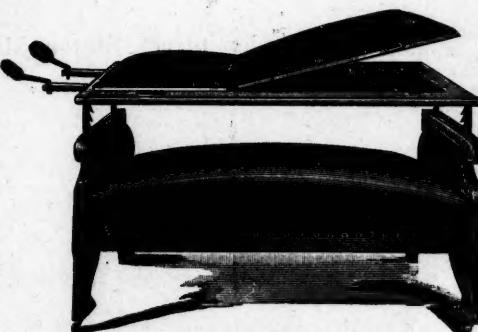
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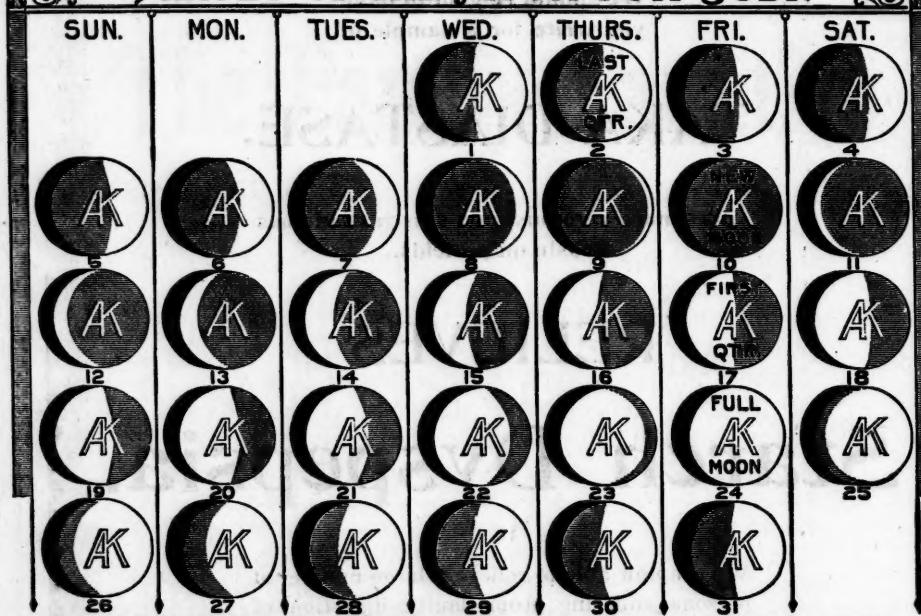
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As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

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